The Habit

ALCOHOL AND DRUG ABUSE DIVISION
MONTANA DEPARTMENT OF INSTITUTIONS
1539 11TH AVENUE, HELENA, MONTANA 59620

JANUARY - APRIL, 1986

A CALL FOR HELP: As the new editor of the Habit, I, Marcia Armstrong, would like to make this publication interesting and relevant to the Montana chemical dependency field. Please send any newsworthy items regarding programs, the comings and going of staff and any other information that you would like to share with the field.

Money seems to be on everyones mind these days, especially how to keep programs afloat in these trying times. Below is an article from NASADAD Alcohol and Drug Abuse Report, December, 1985, explaining the process of the Gramm-Rudman.

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GRAMM-RUDMAN-HOLLINGS TO IMPACT ADMS BLOCK

For FY 1986, it has been estimated that the total appropriation for the ADMS Block Grant and other non-exempt programs will have to be reduced by 4.6%. The current appropriation for the ADMS Block Grant is $490 million. If the projected amount of the reduction is accurate, the ADMS Block Grant will be reduced to 467.46 million. Due to last year's changes in the ADMS Block Grant allocation formula, however, the first $28 million in reductions will have to be absorbed by the same states that previously benefitted from the allocation formula change. Those states include: California, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming, the Trust Territories and Northern Marianas Islands. The remaining states should not receive a reduction in their ADMS Block Grant award until the appropriation falls below $462 million.

The Congress and the Administration must also enact an additional $50 plus billion in reductions for FY 1987. If they are unable to agree on a budget which is below the maximum deficit target for FY 1987, a second series of across-the-board reductions are mandated by the legislation. It has been estimated that a second series of across-the-board reductions would result in an additional 20% cut in non-exempt program budgets. In addition, there always exists the possibility that the Congress of Administration when developing their own budget blueprint, could propose a total elimination of the ADMS Block Grant in order to save other domestic programs, i.e. research.

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Cocaine is one of the most powerfully addictive drugs known. It works directly on reward centers of the brain, producing an even more compelling need than heroin.

Given free access, laboratory rats prefer cocaine to water and food and will continue to self-administer cocaine until it kills them.

The most accurate predictor of cocaine use is previous use of other drugs. Among adults 18 or older who have used marijuana 100 or more times, 74 percent have used cocaine. Among those who have never used marijuana, or used only once or twice, only 2.1 percent have used cocaine.

A sharp increase has occurred recently in persons seeking treatment for cocaine dependence. More than half of all patients seen in an inner-city Chicago drug abuse treatment program in 1983 had a primary diagnosis of cocaine dependence, compared with 3 percent in 1980 and 36 percent in 1982. "Freebasing," which delivers high concentrations of cocaine into the central nervous system more rapidly than any other method of use, was the most frequently used route of administration in 44 percent of patients.

ADAMHA Update, April 1986

DARRYL BRUNO explains the current funding picture for Montana.

PUBLIC FUNDING CONTINUES TO DECLINE FOR CHEMICAL DEPENDENCY PROGRAMS

The public funding that is available for Chemical Dependency Programs is continuing to decline in FY86 and projected to further decline in FY87. State approved programs are basically funded by the earmarked alcohol tax and federal Block Grant funds. The earmarked alcohol tax is tied directly to the volume of alcohol beverages sold in the state and is distributed to the counties based on 85% county population/15% county land area to total state population and area. Federal Block Grants are awarded to local programs on competitive contract basis. The 1983 legislature authorized the expenditure of Block Grant carry-over funds to alleviate any shortfall of earmarked alcohol revenues during FY84 and FY85. This action maintains current level services in FY84 but fell short by $70,066 in maintaining current level services in FY85.

Initially, this infusion of Federal funds offset the reduction of alcohol earmarked tax in the last biennium. With the passage of House Bill 374 increasing the wine tax by 7¢ per liter, and the increase in Federal excise tax on distilled spirits by $2.00 per proof gallon, effective October 1, 1985, it was expected that this would somewhat offset the decline in sales and current level services would be maintained in the 86-87 biennium without any infusion of Block Grant funds.

However, this did not occur. Liquor sales continued to decline more than could be offset by the Federal tax increase, beer sales continued to decline and the wine tax is projected to fall short by over $56,000 from our original estimates in FY86. Again, because of Block Grant fund carry-over, we are able to offset this shortfall of $165,138 by $128,378. Based on our current information, we are projecting that the shortfall of earmarked tax revenue at the county level will fall short in FY87 by $266,049. We will be able to offset some of the shortfall again with Block Grant funds, but to a maximum of $248,000. If this does happen, our carry-over of Block Grant funds will practically be eliminated which will mean then there would virtually be no Block Grant funds available in the next biennium to offset any shortfall at the local level.

In FY87, any infusion of Federal funds to offset the reduction of alcohol earmarked tax is contingent on the available Block Grant funding from the Alcohol, Drug and Mental Health Services Block Grant. At the present time, we have no real indication of how the Gramm-Rudman legislation will effect our federal Block Grant. However, if there is a sizeable decrease, then the reduction at the county level will be severe.

While the earmarked tax and federal Block Grant provide the majority of public funding, the Department also has received general fund for the past 13 years, appropriated by the Legislature to support drug services other than alcohol. The FY86 and FY87 appropriations are for $219,000 each year, which represents about 35% of the total funding for these specialized drug services.

In FY86, there was a general fund reduction of 2% or $4,392. In FY87, because of the projected state general fund deficit, we are expecting an even larger reduction and until the special session is over in June of 1986, the total amount will not be known.

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Approximately 21.6 million Americans have used cocaine at least once in their lives. Four million Americans are "current users," defined as using at least once in the month prior to survey.

Cocaine use among high school seniors increased in virtually all subgroups from 1984 to 1985 -- males and females, college-bound and non-college bound, rural and urban areas, and in all regions of the country except the South.

Another study that has tracked 1,325 secondary school students in New York State since 1971, when they were 15-16, found that by age 28-29, 43% of men and 28% of women had used cocaine, making it the second most frequently used drug, after marijuana.

Total emergency room cases involving cocaine more than tripled between FY 1981 (3,253) and FY 1985 (9,733) in the major cities that report to the Drug Abuse Warning Network.

MONTANA ADVISORY COUNCIL ON CHEMICAL DEPENDENCY

The Montana Advisory Council on Chemical Dependency is a 10 member council appointed by the Governor of Montana to advise the Department of Institutions in the administration, planning and funding of statewide chemical dependency services under Title 53, Chapter 24, MCA. This council was re-created in August of 1985, in accordance with provisions of Sec. 2-15-122 M.C.A. The following is a brief history on how the advisory council was formed over the years and also an introduction of the current advisory council members.

In 1969, the Governor of Montana created the Alcohol and Drug Dependency Commission within the Department of Health to oversee Montana's alcohol and drug abuse issues. In 1971, from the above commission, the Governor created an 18 member alcohol and drug dependency advisory council to comply with Federal requirements for alcohol and drug formula grants under public laws 91-616 and 92-255. The 18 member advisory council advised the Department of Health and the Governor's Office, Addictive Diseases Unit on alcohol and drug issues. In 1975, House Bill 699 was passed and transferred all alcohol and drug agencies under the Department of Institutions. In September of 1975, the advisory council membership was reduced from 18 to 8. This 8 member council continued to advise the Department of Institutions until 1979 when the advisory council membership was raised to 10 members to insure 2 member representation from each of the 5 health planning regions.

In 1982, with the elimination of federal formula grants, and the implementation of the federal block grants, the federal requirements for state advisory council no longer existed. However, Montana continued with it's alcohol and drug dependency advisory council until the 1985 legislative session when it's continuation was reviewed by the State Legislature. The 1985 state legislature, through the legislative appropriation process, felt the need for the advisory council and appropriated funding for its continuation. In August of 1985, the Governor re-created the present 10 member council and changed its name to the Montana Advisory Council on Chemical Dependency. The present Council members are:

William A. Spoja, Jr., Chairman, Lawyer
Lewistown - Health Region III

Joseph P. Plumage, Indian Health Service
Billings - Health Region III

Sharon Pettit, R.N., State Department of
Health and Environmental Sciences
Helena - Health Region IV

Mary Ellen Connelly, State Legislator
Whitefish - Health Region V

Jeannette Buchanan, City/County Health Dept.
Missoula - Health Region V

William E. LaBree, Businessman
Glendive - Health Region I

James A. Gilbertson, Pharmacist
Miles City - Health Region I

A. R. Hagener, County Commissioner
Havre - Health Region II

John Albrecht, Lawyer, Justice of the Peace
Choteau - Health Region II

Vacant Membership - Health Region IV

The above members will serve, at the pleasure of the Governor, until August 1987. Continuation of the Advisory Council into the 1988-89 Biennium will be contingent on the 1987 legislative appropriation process.

The Council regularly meets 3-4 times a year in different regions of the state. Local state approved chemical dependency programs are being asked to make presentations concerning their program services to the Council. Also, advisory council members representing particular program areas are available to hear local program or community chemical dependency problems or concerns. The next advisory council meeting is scheduled for June 5-6, 1986, at the Department of Institutions in Helena, to review fiscal 1987 discretionary funding requests. Chemical dependency program personnel and other interested persons are encouraged to attend.

JOHN HARPER, a certified chemical dependency counselor for Alcohol and Drug Services of Central Montana, Inc., in Harlowton sent an interview with William Spoja to share with the Habit readers.

"Lawyers do not have any kind of special training to deal with the problems of addiction they are going to encounter. It is left to them, their own common sense and their own sense of responsibility to proceed with whatever they think is appropriate."

This is how former Fergus County Attorney Bill Spoja reflects upon his law school training with regards to the disease of Alcoholism in this 1400 word interview conducted on December 28, 1982. He offers keen insight into alcoholism and its implications upon the legal profession. His awareness of the problem, the first hand experience with chemical dependents make him an "expert in his field" within the State of Montana. The universal legal concerns of these diseases are tactfully, yet firmly dealt with in this interview that was previously published in the November 1985 edition of "The Phoenix."

For fourteen years Bill held this position in the central Montana community of Lewistown. He retired in January 1983 to return to private practice. Mr. Spoja still serves on the Governor's Advisory Council on Chemical Dependency, is a member of the State Board of Health and serves on the Board of Directors for Alcohol and Drug Services of Central Montana.

Interview with Attorney William A. Spoja, Jr.

Question: What is the basic problem in dealing with alcoholism?

Spoja: It is exactly the same problem that society at large has and that is the failure to understand. Where there is not a failure to understand, there is an act of denial involved which is a part of the whole alcohol problem in itself. Those who work with individual alcoholics encounter denial either in the alcoholic, the spouse, or both. That makes it that much more difficult to treat. The lawyers who deal with alcoholics are no exception to this. They can either deny the alcoholism themselves or have difficulty addressing the denial of someone else.

Question: What type of training do lawyers receive in law school to deal with chemical dependency situations?

Spoja: Lawyers do not have any kind of special training to deal with the problems of addiction they are going to encounter. It is left to them, their own common sense and their own sense of responsibility to proceed with whatever they think is appropriate.

Question: What percent of the cases involving arrests have you dealt with that are alcohol and drug related?

Spoja: I have never tried to figure out what percentage would be related but I'm trying to think right now of a criminal case that was not alcohol or drug related in some way or another. I don't know that we could blame alcoholism or drug addiction for all the crime that goes on but I would be willing to say that almost all the crime we encounter has an involvement of chemical abuse somewhere within it. I think that is almost an accepted conclusion all the way from Maine to California and from Florida to Alaska.

Question: Can an attorney practice law and deal with alcohol and drug cases and still be honest to society and to the client they represent?

Spoja: I would hope so. I am not willing to do it any other way. I think that by dealing realistically with the problems that come before him the lawyer can succeed. That doesn't mean that you aren't going to have some individual clients who are going to be upset with you. If you are going to realistically deal with their whole problem you have to confront these things. If alcoholism or drug addiction is one of the components of the problem you have got to deal effectively with it. To do otherwise is unethical.

Question: What can a lawyer do in cases involving addictions?

Spoja: The basic approach that any decent lawyer has is to realize that his client; whoever he may be and whatever his problems are; has the right to receive the best legal representation that that lawyer can give. The problem is in the lawyer being able to determine, and being able to present his client with the approach which may be the best for him. If the lawyer doesn't understand the addiction problem then his approach will probably be to

simply follow whatever direction that client initially proposes. That may be the approach of trying to establish or trying to avoid letting the State establish guilt in a criminal case, or helping the client meet his goals in a civil case. The attorney who understands what the problem is before him may realize that by thwarting the State's effort to prove the DUI case, he may be setting his client up to some real problems down the road that are even worse than the one he's contending with then. If nothing else he is condemning his client to suffer the continued ravages of alcoholism. What the lawyer himself may know about the disease could determine which direction he is going to go with the case. Some clients are simply not going to be amenable to the attorney telling him anything other than how to get off.

Question: Is there any support in the legal system for the mandatory jail sentence, no bail, no plea bargain and no release philosophy.

Spoja: Not only is there not much support in the legal system for that philosophy, but it is contrary to the United States Constitution, some laws in the State of Montana, especially the bail bond laws the legislature has set up. It is not going to happen unless there are some major legal changes made somewhere along the line. I don't foresee these changes.

Question: You serve on the Governor's Advisory Council for Alcoholism and Drug Addiction and the State Board of Health. What interest is there for this problem on those levels?

Spoja: At the Governor's level there has been a great deal of interest and concern about the problem of Alcoholism. The difficulties come when you mix the costs and problems of Alcoholism with the cost and problems of other State functions. As a result social problems of all kinds, Alcoholism in particular, gets pushed back a bit from time to time.

Question: What can communities do to address their alcohol and drug problems with their available resources?

Spoja: Communities need to recognize that in fact we have this terrible, terrible disease amongst our people. The communities need to encourage those groups working to overcome alcohol problems as much as possible. Encourage public officials to deal with it with some wisdom and not merely punish those who get drunk but have not yet realized they are still responsible for their actions. Once we have dealt with the offense we need to be wise enough to recognize that we can't lock people up forever.

Question: Where does the Alcohol and Drug Counseling Center in a community fit into the lawyer's tools for defending or dealing with an alcohol or drug addicted client?

Spoja: Most lawyers probably don't think of those resources until they get into a difficult situation, but some are recognizing that an effective alcohol and drug service can be relied on to do some good things and that the people staffing those services are professionals. Lawyers are beginning to turn to that resource and recognize that it can help them out.

Question: What's the public reaction to officials who deal with the disease and the legal actions of the alcoholic?

Spoja: I've found that if people know what is really going on, they have little trouble with reasonable actions of the courts. It's when they don't know what is going on that the problems erupt. When people realize that the bulk of crime is caused by drug and alcohol addiction we can begin to deal with it.

Question: What is the attitude of the legal profession in Montana?

Spoja: The Montana Bar Association released a publication in November of 1982 and has made a very serious effort to look at what Alcoholism does to attorneys in Montana. It has also picked up on the materials coming out of the American Bar Association which is also concerned about what's happening to attorneys across the country. Just as the American Medical Association has to worry about the doctors who are on drugs and alcohol, the American Bar Association has to worry about the same thing. This is true in every professional or trade organization.

Interview (Continued)

Question: Does the legal system inhibit dealing with an alcohol problem when crimes against society are involved?

Spoja: Sure. The fact that any person charged with a crime needs to be properly represented to the full extent of their rights under the law means that the State has to be put to the test of proving its case. At times it would be faster and easier if you could dive right straight to the heart of the alcohol problems and all the things that are going on, do something with it and get on your way. As I mentioned that would short cut a whole bunch of legal protections which I don't think our society wants to do. The sanctity of the rights of the individual under our constitutional system is too important. We have to be willing to suffer some loss for that particular gain. Even my great concern for people with chemical problems would not let me ignore the constitutional rights they have. The fact that we have not yet come to grips with chemical addiction doesn't mean that we should throw away those legal protections. We need to keep a balanced approach to the whole problem. We're improving but we have to admit that we are only pilgrims on the road and I think maybe we are still on a gravel road. We haven't gotten any blacktop on it yet. We've a long way to go.

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Among 18-25 year olds, 28% have at least tried Cocaine.

An estimated 60,000 children as young as 10-13 have tried cocaine.

Cocaine use by high school seniors reached its highest level ever in 1985 -- with 17% of the students having tried cocaine at some time in their lives, and 6.7% using it within the past 30 days.

On the basis of previous high school classes, it is estimated that nearly 40% of 1985 seniors will use cocaine by the time they are 25-26.

ADAMHA Update, April 1986

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CDPM's Corner of the Habit

CHEMICAL DEPENDENCY PROGRAMS OF MONTANA

Chemical Dependency Programs of Montana, Inc. [formerly called Alcoholism Programs of Montana] has been in existence since 1975. CDPM is an organization composed of incorporated programs within Montana whose primary business purpose is the treatment of chemically dependent individuals. The members of CDPM currently represent 33 counties within Montana.

There have been many myths generated around this organization over the years. As a result of these myths, John Brekke from the Wilderness Treatment Center prepared a set of "facts vs. myths". The Alcohol and Drug Abuse Division has generously consented to providing us space in "The Habit". With this first article we would like to share the "Facts vs. Myths" document about CDPM.

Upcoming articles will address expanded membership of CDMP, certification of counselors, legislative issues affecting the alcohol and drug counseling profession, and more. If you have any questions concerning the articles or the organization, please call one of our officers.

Harold Schutt, President
Providence, Great Falls
727-2512

Mike Ruppert, Vice President
Alcohol Services of Gallatin County
Bozeman 586-5493

Douglas D. Settles, Secretary/Treasurer
Shodair Adolescent, Helena
449-7630

CHEMICAL DEPENDENCY PROGRAMS OF MONTANA

FACTS VERSUS MYTHS

MYTH: 1. It only benefits urban programs and Western Montana programs.

FACT: 1. A. 1974 House Bill 909 created funding that has established most rural programs and since have maintained services in all rural counties. CDPM lobbied hard for this bill, and every legislation since they have addressed alcohol tax that benefits all rural programs.

B. 1977 increase tax on liquor to 10% and $1.00 per barrel of beer, also a great benefit to rural and urban programs alike.

C. 1985 - Refined wine tax made it possible for rural programs to continue to exist.

MYTH: 2. All members are only concerned with their specific program and don't care about the rest of the state.

FACT: 2. Each member has a primary concern with their specific needs, out-patient v. inpatient, private v. public, etc. This is only natural and will continue, but our organization is the best mechanism we have available to meet our needs and the needs of the entire field of chemical dependency.

MYTH: 3. Nothing has changed in the past 10 years, we are still discussing 10 year old issues.

FACT: 3. It is true that there are many issues that we address every year and, at times, nothing seems to change. Ten years ago, however, files were kept on index cards, there were no fees for service, insurance coverage, certification process, quality assurance in our evaluation, every director had to carry a case load, and mental health was moving to take over all A & D programs. So, even though there are some issues that are the same, we have come a long way in CDPM.

MYTH: 4. It costs too much to be a member.

FACT: 4. The financial benefits to all programs because of CDPM lobbying efforts and community involvement has been the lifeline of all programs in the state. The problem is, everyone benefits whether they are members or not. We will all benefit more, however, if we are a larger organization representing a larger portion of the state. CDPM this year has an incentive program for members and non-members to be involved in the program to see the benefits. Membership dues are $150 for $100,000 budget and below, $250 for $100,000 plus, and $350 for $200,000 or more.

MYTH: 5. CDPM does not represent us at the state level.

FACT: 5. CDPM meetings are always attended by the Alcohol and Drug Division, primarily their Administrator, Bob Anderson. At each meeting there is a willingness to listen and act on suggestions by CDPM members. Again, with wider representation, the more influence we will have. Any administration rule change is discussed at CDPM meetings prior to the hearings.

MYTH: 6. CDPM does not represent the progressive programs so we need another organization that does.

FACT: 6. If we, in the field of alcoholism, present a divided front at the legislature, there will be nothing accomplished until we can show legislators that we are united again.

We have been a very successful lobbying organization in the past, and there is a tremendous need for us to continue being successful.

In addition, CDPM seems to be headed in a more progressive direction in the future. We are expanding our organization to include all professionals and lay people interested in the field of chemical dependency; we will be taking a more active role in training and education of chemical dependency professionals; our annual meeting [in the fall] will have nationally known speakers. Watch "The Habit" for upcoming information about these exciting new developments.

MARILYN LEMAICH
Speaks out About the National Federation of Parents

"In November I was able to attend the National Federation of Parents for Drug Free Youth Conference in Washington D.C. and came away with renewed enthusiasm for our case-----drug free youth! This national organization is one that has done great things for our youth through the parents' movement. I heard more than one national figure speak to the effect that this grassroots movement has had a positive impact in bringing about attitudinal and behavioral changes as well as legislative changes where out kids and chemicals are concerned.

We Montanans need to begin to work together as they have been doing in most other states across the country-----setting up networks of parent and community organizations-----fighting for drug free youth. Working together we can make a difference!" Marilyn Lemaich (Missoula)

ATTENTION: PARENTS' and COMMUNITY PREVENTION GROUPS

What is happening across the country in the prevention area that is accomplishing the goals we are all working for?

A STATE NETWORK!!!!!

Through a network we would be able to work together in;

1. sharing ideas, information & resources
2. assisting in the formation of new groups
3. increasing communication
4. providing a central resource center
5. coordinating programs and strategies
6. gaining a stronger base of influence and support throughout the state for the parent movement
7. lobbying for appropriate legislation.

If you and your group are interested in becoming involved in this network of "sharing and caring", please let me know as soon as possible. As part of the network we would be able to share information through the use of a newsletter published on a regular basis. Working together we can make a difference!

Marilyn Lemaich, President
Missoula Parents for Drug and
Alcohol Award
5 Lincoln Hills Drive
Missoula, MT 59802

Phone: (406) 728-5108

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Approximately 6.2 million young people age 12-17 have used marijuana at some time during their lives; 2.7 million have used marijuana in the last month; 4.8 million have used marijuana in the past year.

Nearly two-thirds (61%) of all American high school seniors use an illicit drug at least once before they finish high school; 40% have used drugs in addition to marijuana.

Cocaine has been tried by at least 17% of seniors in the Class of 1985--the highest rate observed so far in the National High School Senior Survey.

Approximately 80% of 1985 seniors acknowledged the harmful effects of using cocaine regularly [an increase of 10% since 1979]; but only about 34% saw much risk in experimenting with it.

RIMROCK OPENS PUBLISHING DIVISION

Rimrock Foundation recently broadened its range of services to the community by opening a literature division called Rimrock Publications. Responding to an increasing need for educational and training literature, Rimrock will be making pamphlets, books and audio-visual material available on a purchase or rental basis. In addition, they will be publishing their own series of pamphlets on chemical dependency counselor training later this year. The Foundation also is encouraging colleagues in the field to submit manuscripts for publication by Rimrock on subjects related to dependency issues. These may be sent to Mr. Hugh Kilbourne, Rimrock Publications, Box 30374, Billings, MT 59107. The Foundation hopes that this new addition to their facility will provide a valuable service to the chemical dependency field and the community at large in the Montana area.

Rimrock's training tape library includes:

TIME	TOPIC	PRESENTERS
[195 min.] 2 Tapes	Clinical Treatment Planning	Richard Weedman. Natl. Consultant Alcoholism Treatment
[150 min.] 2 Tapes	Adolescent Issues in CD Treatment	Mona L. Sumner, MHA Gary Bounous, ACSW
[50 min.]	An Assessment Process for Eating Disordered Patients	Mona L. Sumner, MHA
[75 min.]	Overview of Eating Disorders	Dr. George Sheckleton
[65 min.]	Application of Neuro-Psych Testing in CD Patients	David J. Campbell, MS
[120 min.]	Conducting Mental Status Examinations	Psychiatric Team
[85 min.]	The Chemistry of the Brain	Dr. Neal Ely
[80 min.]	Pharmacology of Marijuana & Cocaine	Dr. Neal Ely
[60 min.]	AIDS	Dr. Ronald Smith
[70 min.]	What Shall We Do With This Kid?	Rimrock Foundation Adolescent Care Team
[75 min.]	Families Under Stress	Rimrock Foundation Therapists

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Programs in Montana (Continued)

Home Free as Submitted by Gary Gullickson,

SECOND STORY in Bozeman

The start of a new program in any community is always an event, and very time consuming. The idea came from two local citizens while traveling in Bend, Oregon.

The idea, giving bar patrons a ride home, should they so need or choose, was not new, and implementation seemed a stumbling block in the past.

Areas in the past that had presented problems were:

1. liability insurance
2. authority to transport persons
3. exposure [advertising]
4. 24 hour call number
5. money
6. positive community input and participation in program.

The two community citizens took the task well in hand and solved the problems in the following manner:

1. organized a group of concerned citizens to form an official committee to see if implementation was possible.

2. solved liability insurance problem by contract with the local Public Service Commission certified cab company.

3. The local cab company agreed to provide rides for a flat fee to a designated area within the city limits of Bozeman. To handle rides must be from an establishment to a home. No rides from establishment to establishment. An agreement is being worked on between the cab company and a local chemical dependency program to provide referrals if someone is a high frequency rider.

4. A local radio station provided manpower and support as a community service project for initial implementation of program. They also provided a tremendous amount of radio advertising and a 24 hour telephone number to dispatch rides.

5. They raised money by selling membership to businesses that dispensed alcoholic beverages. These membership businesses received a number of vouchers for rides.

6. Became a member of an existing non-profit corporation so all donations and memberships were tax deductible from the beginning of the program, instead of waiting the 6 to 8 month period required for tax exempt status. Also, purchased bookkeeping service from same organization.

7. Enlisted more and various members of community to give the Board a broad base of community exposure to work from [insurance, sheriff, police, private citizens, newspaper, chemical dependency program, etc.]

The program was implemented and running strongly in 3 months. Currently, they give an average of 300 rides per month.

For more information contact:

Second Story/Gallatin Council
Box 1375, Bozeman, MT 59715
Phone: 587-1238

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One out of every 20 high school seniors (4.9%) smokes marijuana on a daily basis.

Approximately 30% of high school seniors have smoked cigarettes during the last month, a substantial proportion of whom are daily smokers.

ADAMHA Update, April 1986

Programs in Montana (Continued)

WILDERNESS TREATMENT CENTER To Be In National Geographic

In January of this year, National Geographic notified John Brekke, the Director of Wilderness Treatment Center in Marion, Montana that they were interested in utilizing the program for an article they are doing about Glacier National Park. In March, Lowell Georgia, photographer for the magazine accompanied a group of patients from Wilderness Treatment Center into the Park for photographing of winter activities.

This adolescent/young adult program for chemically dependent males utilizes the Park and surrounding wilderness areas for a portion of their overall treatment program.

- Wilderness Treatment Center has a one year trainee program approved by the Alcohol & Drug Abuse Division. This program admits new trainee [one] every 6 months. If you are interested in this program please contact Pete Anderson at 854-2832.

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CENTER FOR ADOLESCENT DEVELOPMENT, INC.

A new program geared to middle school students turns peer pressure into positive solutions to peer problems. The Teens in Partnership [TIP] program aims to strengthen the informal helping networks found in every school. Mountain Bell, through a substantial contribution, has joined with the Center for Adolescent Development and communities around the State of Montana to provide this model prevention program which begins this summer.

Although other programs offer prevention training for adolescents, few are open to 7th through 9th grade students. Mountain Bell, recognizing the need for such a program in Montana, recently approved two years of funding, with $40,000 available for the first year's operation. "With all the cuts in government services, it's great to see a major corporation stepping in where we really need it," says program director Ira Feiger.

The need for help in adolescents is often evidenced by poor grades, absenteeism, suicide, depression, the abuse of alcohol and other drugs, physical violence, teen pregnancy, and other problem behaviors, according to Feiger. It doesn't have to be that way. Through TIP, young people will be taught to positively apply peer pressure to their difficulties.

Students and advisors from schools taking part in TIP will be selected through an anonymous school-wide survey and then trained in prevention and intervention skills during a training session to be held August 3-8, 1986 near Big Timber. Back at school, program graduates will be expected to put what they've learned into action, supported by the Center.

"We aren't training students to substitute for professional help," Feiger emphasizes. "We're just giving them some information and the tools to help themselves and their troubled friends."

The highly structured format developed for the Montana Teenage Institute on Substance Abuse [another CAD program] will be used in this new program. Local businesses, service clubs and other community agencies have shown enthusiastic financial support for all CAD programs in the past, according to Feiger.

At TIP's Camp on the Boulder, participants will develop their personal helping skills as they learn more about the major problems middle school students face, find out how to use local resources and become sensitive to their own limits as helpers.

Suicide, stress, self concept, peer pressure, family relationships, drug and alcohol abuse, nutrition, physical growth and development, mental and physical health, sex and marriage are just a few of the topics to be presented.

TIP is one of several programs the Center for Adolescent Development administers which promote the personal and social growth of adolescents. The Montana-based private non-profit corporation's programs include the Rainbow Connection and the Rural Prevention Project, as well as the TIP and MTI programs.

For further information contact: Ira Feiger, P.O. Box 345, Helena, MT 59624, 442-2733.

ST. IGNATIUS Action Project Features Multi-Cultural Apprcach

The St. Ignatius Community Action Project on Chemical Awareness grew out of a unique agreement made between the Flathead Tribal Health Department and St. Ignatius School District #28 in 1984. The Confederated Salish and Kootenai Tribal Council made a decision at that time to close down the residential alcoholism treatment center in Ronan and to focus instead on prevention. Two schools, St. Ignatius and Arlee, were each given $15,000 in grant money for each of two years, on the condition that each develop a school prevention/intervention program with demonstrable community support.

The St. Ignatius Community Action Project has a community group--the Community Action Team on Chemical Awareness--and a school group--the school CA/RE [Chemical Awareness/Responsive Education] Team. Both groups have had two busy years.

"A large block of the grant money has gone toward staff and community educational workshops," according to Chuck Tellier, Action Team Chairperson. "It was felt at the time that we first needed a shared perspective on this issue, which has caused so much pain in our community."

Several workshops were held on a variety of related topics, Tellier said. Two more community workshops staff training days have also been planned for this spring.

"What is perhaps a unique aspect of Action Project planning has been a conscious decision from the beginning to involve both the Native American and the non-Native communities," he added.

One of the key resources drawn upon has therefore been the Four Worlds Development Project, a Canada-based community development organization.

"The Four Worlds Project was developed primarily by and for Native people, and its philosophy is rooted in Native cultural perspectives," Tellier said. Another Four Worlds workshop is being planned for early May.

Action Team officers this year are Tellier, Barbara Papenfuss, Marti King, and Alice Miller.

The school CA/RE Program has two major components, according to Mary Herak, the school's Intervention Specialist and this year's CA/RE coordinator. One component is the human potential program, which has five equally-weighted focuses: self-esteem building, coping skills, refusal skills, decision-making skills, and basic chemical awareness information.

"Thanks to the gift from the Tribes, we've been able to purchase the most highly recommended human potential/chemical awareness program now available, the "Here's Looking At You Two" K-12 curriculum," Herak said. "Two staff and one community member were sent to Seattle for a week-long "training of trainers" workshop last summer, and two other staff just returned from intensive training in teaching the refusal skills section. These people are excited about the possibilities the curriculum has for enhancing the entire classroom environment."

The curriculum will be introduced in grades K-2 this spring, and in the upper grades next year, when the rest of the materials arrive.

The school also purchased the Four Worlds mini-curriculum, which is based on traditional Native American values, Herak said, and this is now under review by selected staff.

The second component of the CA/RE Program is a student assistance program. "This is the part of the program that recognizes that some students are already using alcohol and other drugs," Herak commented.

A 'core team' of trained staff meets regularly to talk about ways to best offer assistance to students who are identified as having problems that may be drug related.

"We're still in early stages of planning," Herak said, but we're very pleased with the widespread support and cooperation we've found in this school and community."

The next step in implementing the CA/RE plan is to send five high school students to the Montana Teen Institute, and possibly to develop a cross-age student tutoring group, or a variety of support groups.

"We have lots of ideas, and there's every sign that this program will be one that will last," Herak observed. "People across the country, and certainly here in our Reservation community, are reaching a limit of despair and hurt around this issue. There's a great readiness for creative, positive change."

HOW BUTTE HANDLES DRUG AND ALCOHOL PROBLEMS

A documentary entitled "The Time of Our Lives" was written and filmed in Butte. The film was written by ten senior students from Butte Central and Butte High. It tells the story of two Butte students who were killed in an alcohol-related car accident on March 8, 1984. The film shows interviews with the families and friends of the students killed and recreates high school students planning and attending a keg party. The two boys were killed after attendance at a kegger. The documentary is Butte's effort to deal with the problem of teenage drug and alcohol abuse in their city.

DRINKING AND DRIVING: THE TOLL, THE TEARS

A widower, a teenage girl, a prisoner, a stepfather, a woman haunted by the night her car killed two little girls...These people and others trapped in the aftermath of alcohol-related traffic accidents tell their stories in the powerful documentary DRINKING AND DRIVING: THE TOLL, THE TEARS, airing nationally over PBS on Wednesday, May 7, at 9 pm ET [check local listings].

If this one-hour long program has unusual intensity and depth of feeling, it may be traced to its unique origin. In July, 1984, Washington television reporter Kelly Burke had been drinking with friends after a long day's work. Driving home, he was involved in a crash in which a man was killed. At his trial, Burke suggested--and the judge agreed--that making a documentary as a community service be a part of his sentence.

His method was simply to let people tell their stories. And they do, with remarkable candor and poignance. They talk about how it feels to have their lives changed forever by a drunk driver. In some cases, they are that driver. All those interviewed share very personal reflections in their own words. The viewer may not agree with all that is said, may at times feel uncomfortable, or sad, or angry. The documentary is a very human one; it answers some questions, it raises many more.

For those viewers wanting more information after the program, WETA has prepared a Resource Guide, available upon request from local PBS stations. In a one page summary, it presents basic facts about the hazards of drinking and driving, includes some suggestions for prevention, and lists national and local resources.

An eight page Education/Discussion Guide and program video-cassettes for ages 15-90 will also be available from WETA for purchase. The Guide will focus on issues of drinking and driving raised in the documentary, provide background information, contain discussion questions, and include an annotated bibliography and extensive list of national and local resources. For information, contact Educational Activities, WETA Box 2626, Washington, DC 20013 or call (703) 998-2709.

DRINKING AND DRIVING: THE TOLL, THE TEARS was produced by Kelly Burke. It is presented over PBS by WETA/Washington, D.C., which will produce a brief wraparound segment. Producer for the wraparound is Sue Ducat; executive producer is Ricki Green. Major funding for this program was provided by Mid-Atlantic Toyota Distributors, Inc., a subsidiary of the Frederick Weisman Co.

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About one in 20 seniors (5.0%) drinks alcohol daily.

Approximately 92% of all high school seniors have used alcohol; 66% used alcohol in the last month, and 86% used it in the past year.

Nearly half (45%) of boys and more than 1/4 (28%) of girls in the 1985 senior class report heavy party drinking [five or more drinks in a row] on at least one occasion in the two weeks prior to the 1985 survey.

Motor vehicle accidents involving alcohol are the leading cause of death for young Americans aged 15 to 19, accounting for 45% of fatalities in this age group.

Although 16-24 year olds comprise only 20% of licensed drivers in the U.S. and account for less than 20% of total vehicle miles traveled, they are involved in 42% of all fatal alcohol-related crashes. Close to 8,000 people between 15 and 24 were killed in alcohol-related traffic accidents in 1984, and an additional 220,000 were injured.

ADAMHA Update, April 1986

MOST EXPENSIVE SANCTION MAY NOT BE BEST FOR DRUNK DRIVERS

Jail is the most expensive sanction for drunk drivers -- and it may not be the best.

That's one of the conclusions reached in a new study by the National Highway Traffic Administration and the American Correctional Association. The study is entitled "The Drunk Driver and Jail."

"Sixteen states now have legislation requiring jail or alternative sanctions for the first-offense drunk driver, and 41 states have laws requiring jail sentences [from two days to six months] or other sanctions for those found guilty of DWI [drunk driving] a second time," according to the study.

"Putting criminals in jail is only one of many correctional options. Moreover, increasing the size of local jails or building new ones is likely to be one of the most expensive and difficult of the options available for managing drunk drivers."

Building jails costs $43,000 per bed, said the study -- and that's only the beginning. It costs up to $17,000 per year to maintain an offender in jail.

"Add to these costs the problems already faced by many jails -- overcrowding, lack of personnel, lack of needed programs and services such as suicide screening -- and it is easy to understand why jailing the 1.9 million DWI's arrested each year will impose enormous new demands on correctional programs and services and the limited funds available to them," says the study.

The study goes on to note that "most drunk drivers are classified as low-risk, non-violent offenders who have no prior criminal history...Correctional options other than secure incarceration can often be used to restrict their freedom of movement and monitor their activities."

There is so far little data available on the effect of jail on drunk drivers, the study notes. "One sanction that has proved highly effective in reducing alcohol-related traffic accidents is license suspension or revocation."

The study notes that there is general agreement that drunk driving offenders should pay fines and fees to cover as much of the costs of their correctional alcohol treatment programs as possible. "Many feel that DWI's should also make restitution to the community, either directly to victims or through payments to general victim compensation funds. [Interestingly, most drunk drivers are not arrested as a result of a traffic accident and therefore have no victim.]"

The study adds that "more than 20 states have established unpaid work on behalf of the community as an alternative to short-term jail sentences for drunk drivers. Properly administered, community service programs offer the benefits of reducing correctional costs and jail overcrowding while providing useful services to communities and a more constructive penalty for non-violent offenders."

Most convicted drunk drivers are employed and many professionals think they ought to be placed in work release centers or in intensive probation supervision so they can be free during business hours to continue earning incomes and help reduce the tax burden of correctional programs, according to the study.

The five volume study is free. It may be obtained by writing or calling:

Publications Division
American Correctional Association
4321 Hartwick Road Suite L-208
College Park, Maryland 20740
Phone: (301) 699-7600

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About 80 percent of 1985 seniors acknowledge the harmful effects of using cocaine regularly, but only about one-third see much risk in experimenting with it.

49% of high school seniors reported in the 1985 survey that it would be easy for them to get cocaine.

ADAMHA Update, April 1986

RESEARCH REVIEW: DRINKING AND DRIVING COUNTER-MEASURES

One of the more persistent recent issues in dealing with the problems of drunk driving concerns the relative effectiveness of two different counter-measure approaches: license action v. treatment.

LICENSE ACTION

The more traditional and more widely used approach is license action. This entails suspending or revoking the license of a motorist convicted of driving under the influence of alcohol [DUI]. The general rationale for this approach is that, in DUI cases, society should be primarily concerned with driving behavior and with teaching deviant drunk drivers an appropriate lesson by removing the driving privilege for a relatively long period of time. Implicit in this rational is the assumption that, during the course of the elapsed suspension time, the driver will somehow have learned his/her lesson and will therefore not repeat the offense of driving under the influence of alcohol. In addition to this specific deterrent effect, the widely circulated public information that "DUI drivers lose their license for a year" is supposed to function as a general deterrent for those who have never been arrested for DUI. A further benefit of license action stems from the protection of public welfare assumedly achieved by "quarantining" the dangerous DUI driver from the highways for a year or more. The above rationale is all bolstered by the fact that license action is a simple straight forward sanction which is relatively easy and inexpensive to administer and which seems intrinsically "to fit the crime."

TREATMENT APPROACH

The more recently developed treatment approach consists of having a convicted DUI driver enroll in some sort of special program, variously referred to as involving education, re-education, counseling, rehabilitation, therapy, etc. The general rationale for the treatment approach is that a DUI conviction is often a manifestation of a drinking problem which pervades most facets of the individual's life: his family relations, his job, his leisure time, etc. Thus, the DUI conviction should ideally serve as an early warning, and society should attempt to re-educate and rehabilitate such individuals. Until very recently, either one approach or the other was used in any given case. Thus, the person referred to a treatment program was typically able to retain their driving privilege by enrolling in and then successfully completing the program. The license action was typically used if no treatment program was available, if the person did not qualify for a treatment program, or if the person either withdrew or was expelled from the program.

RESEARCH PROBLEMS

Attempts to determine which of these two countermeasure approaches is more effective have been frustrated by many problems, the most fundamental of which is deciding what criteria should be used to measure "success" or "impact." In the past, members of the traffic safety and jurisprudence communities have tended to select and emphasize those outcome criteria which are measured in terms of motoring variables, such as subsequent accidents and reconvictions. By contrast, members of the alcoholism and service provider communities have attempted to emphasize outcome criteria which are specified in terms of life style variables, such as changes in drinking behavior and social stability.

REVIEW CONCLUSIONS

A recent review of the literature concerning the effectiveness of these two counter-measure approaches provides some preliminary conclusions.

There is no question that license suspensions have a significant effect in reducing the accident and drunk driving frequency of convicted DUI offenders. At the same time, studies clearly show that the license suspensions are routinely violated.

The existing evidence also shows that license suspensions are more effective than any known form of post-conviction, alcohol education, or rehabilitation, including alcohol education programs that are paired with license restrictions. There is, however, some suggestive evidence from two recent studies showing that particular alcohol rehabilitation programs may be slightly superior to license suspension in reducing recidivism, although the effect is too small to reduce the total accident frequency.

When treatment approaches were reviewed, the less traditional and less obtrusive forms were found to be as effective, if not more effective, than intensive alcohol therapy.

Reviewers suggested several methods of increasing the effectiveness of both the education/rehabilitation programs and the license suspension approach. Only a small proportion of detected suspension violators are prosecuted for this offense. Increases in the detection and conviction rate for suspension violators would enhance the deterrent value of license suspensions.

Readers may obtain a copy of the entire review article [with references] for $2.00 [prepaid] from the Alcohol and Drug Information Clearinghouse, Alcoholism Council of Nebraska, 215 Centennial Mall South, Room 412, Lincoln, NE 68508.

FROM: "Alcohol, Drugs, & Driving:
Abstracts and Reviews,"
Volume 1, No. 4,
Oct-Dec, 1985

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A.C.T. PROGRAM TAKING EFFECT

By Mark Clark

A new program for D.U.I. offenders has been implemented across the state on January 1, 1986. It is known as the A.C.T. Program. The name refers to the three levels of the process; Assessment, Course and Treatment. Since the program is new I will give a brief description of each component.

Level I - Assessment is the process used to screen, assess and evaluate the offender, to determine the extent of their chemical use or dependency, for referral to levels II or III. This determination is made by a certified or eligible chemical dependency counselor. The offender will then be classified as 1) unidentified, 2) misuser, 3) abuser, or 4) chemically dependent.

Level II - Course is an educational component involving a minimum of four sessions. These classes involve instruction through lectures, videos and films. The curriculum includes; expectations and attitudes, consequences of drinking and driving, physiological effects of drinking, social and psychological effects of drinking, and self-assessment.

Level III - Treatment is recommended for those offenders who are diagnosed as chemically dependent as a result of the assessment phase. Repeat offenders are also referred to treatment after completing a current evaluation. Recommendations are made to the courts for an appropriate treatment process, based upon the individual offenders needs. The referring Judge is notified only in the case of non-compliance.

There has been much confusion as to who can offer the DUI ACT Program. Only state-approved chemical dependency programs and only in the city or county that they are approved can offer the ACT Program.

This new method establishes a more uniform process for programs providing DUI services throughout the state. Now it is easier for the offenders, courts and other interested community members to understand the procedure. There are certain adjustments to be made while it is being implemented, but in the long run Montana will be providing a better quality of services for those individuals who are referred to the ACT Program.

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DUI - MONTANA COURT SCHOOL DATA

By Phyllis Burke

On July 1, 1985, the state approved C/D Programs that conduct a Court School for DUI offenders began reporting on a new report form. The new reports consist of information that is more relevant to DUI offenders than the previous reports contained, and eliminated some data that was not pertinent and required considerable time to collect.

The computer program to record this data has been completed and entry of the information for July through March has begun. We should have the DUI data for this 7 month period within 60 days and will include it in the next publication of the Habit in August.

Montana Court School Data (Continued)

The Court School data will include socio-demographic information such as age, race, sex, marital status and employment status, along with data regarding the number of previous DUI convictions and DUI schools attended, and if the participant has previously received chemical dependency treatment. Of particular interest on the new forms is blood alcohol content at the time of arrest, if available, and this will be reported on a range from .05 to .50+. The Court School discharge information will show the results of the assessment and evaluation and if chemical dependency treatment was recommended.

The Alcohol and Drug Abuse Division will be conducting training for data coordinators and chemical dependency counselors on completing the Alcohol and Drug Information System report forms on a regional basis in late May and June. This will be a 6 hour workshop and will take place in five cities throughout the state. Specific information regarding the dates and places where this training is to be conducted will be mailed to Montana chemical dependency programs the latter part of April.

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MINORS IN POSSESSION MANUAL

ADAD has developed the Minors in Possession [MIP] manual which meets our minimum standards. A copy has been sent to each state approved program. If you would like a copy please write to ADAD, Department of Institutions, 1539 11th Avenue, Helena, MT 59620.

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CERTIFICATION UPDATE

Beginning October 1, 1985, there have been various rules changes. The most important change is that all programs must hire eligible counselors. An eligible counselor is defined as being in the certification process, and having a minimum of seventy (70) points. An eligible counselor will have one year from employment date to become certified.

Any applicant who has been on the registry for two (2) years without obtaining sufficient points for certification will be dropped from consideration. Those who are dropped may not reapply for two (2) years.

Documentation is required on all items before the written examination can be taken.

Counselor trainee and internship programs that previously did not have ADAD approval must contact this office for approval. These programs are now involved in the evaluations done by ADAD.

There is no carryover of points from one certification period to another. It is important to keep the certification section current on addresses and any changes in names.

There are 390 persons certified in chemical dependency, prevention education and/or management supervision. There are 358 certified chemical dependency counselors, 50 with prevention education endorsements and 63 with a management supervision endorsement. Twenty persons have obtained all three endorsements. There are 157 persons with certifications ending June 30, 1986.

NEWLY CERTIFIED PERSONS

Certification No.	Name	Endorsement
345	Lynne M. Boone	Chemical Dependency
346	Robert Piccolo	Prevention Education
347	Paul Podmajersky	Prevention Education
348	Karen Red Tomahawk	Chemical Dependency/ Prevention Education
349	John Harper	Chemical Dependency
350	David A. Bosch	Chemical Dependency
351	Dudley Dana	Chemical Dependency
352	Larry Engelhardt	Chemical Dependency
353	John R. Honsky	Chemical Dependency
354	Jack A. Pipe	Chemical Dependency
355	Sandra Diane Sesler	Chemical Dependency
356	M. Dawn Kurzka	Chemical Dependency
357	Billie Jean Traynham	Chemical Dependency
358	Neil Egan	Chemical Dependency

Newly Certified (Continued)

359	Robert L. Escarcega	Mgmt. Supervision
360	Gail Hager	Chemical Dependency
361	Bonnie Livingston Pipe	Chemical Dependency/ Prevention Education
362	Roger Knows His Gun	Prevention Education
363	Ramona L. Krebbs	Chemical Dependency
364	Debbra L. Lewey	Chemical Dependency
365	Deborah A.D. Senn	Chemical Dependency
366	Roderic J. Senn	Chemical Dependency
367	Joyce Dritshulas	Chemical Dependency
368	Marilyn K. Lemaich	Chemical Dependency
369	James C. Baird	Chemical Dependency
370	Herbert W. Lay	Chemical Dependency
371	Cynthia D. Gardner	Chemical Dependency
372	Nancy M. Stemm	Chemical Dependency
373	James R. Mason	Chemical Dependency
374	William J. Erickson	Chemical Dependency
375	David S. Wyatt	Chemical Dependency
376	Patricia K. Russ	Chemical Dependency
377	Richard Schaeffer	Chemical Dependency
378	Charles Bearcomesout	Mgmt. Supervision
379	Ben Armentrout	Prevention Education
380	Charlotte M. Coppinger	Chemical Dependency
381	Naomi Bowers	Chemical Dependency
382	Myron A. David	Chemical Dependency
383	Eric Eggen	Chemical Dependency
384	Lawrence Laket	Chemical Dependency
385	Sue-Ann Nystrom	Chemical Dependency
386	Becky J. Piske	Chemical Dependency
387	Twila Raisl Christman	Chemical Dependency
388	Mary Ann Schimke	Chemical Dependency
389	Cristina Monarrez	Chemical Dependency
390	Catherine Slusser	Chemical Dependency
196	Kelly Richards	Prevention Education
140	Stephen King	Chemical Dependency
121	Ben Asencio	Chemical Dependency

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ESTIMATED COSTS TO U.S. SOCIETY IN 1983
OF ALCOHOL ABUSE, DRUG ABUSE, AND MENTAL ILLNESS
[In millions]

Core Costs	Alcohol Abuse	Drug Abuse	Mental Illness	Total
Direct				
Treatment and Support	$ 14,685	$ 2,049	$ 33,445	$ 50,359
Indirect				
Mortality	18,151	2,486	9,036	29,673
Reduced Productivity	65,582	33,346	4,048	102,976
Lost Employment	5,323	405	24,044	29,772
Related Costs				
Direct				
Motor Vehicle Crashes	2,667		-	2,667
Crime	2,607	6,565	966	10,139
Social Welfare	49	3	259	311
Other	3,673	677	831	5,181
Indirect				
Victims of Crime	192	945	-	1,137
Crime Careers	0	10,846	-	10,846
Incarceration	2,979	2,425	146	5,549
Motor Vehicle Crash	583		-	583
Total	$116,674	$59,747	$72,775	$249,196

ADAMHA Update, April 1986

DRUGS IN WORKPLACE CONSENSUS REACHED

By James Helsing of
Alcohol, Drug Abuse and Mental Health News [ADAMHA]
March 1986 Volume XII Number 3

Health and legal experts from business and industry reached a consensus at a national conference on drug abuse in the workplace earlier this month that every company should consider developing a policy on drug abuse by its employees, and a program to help them get treatment if they need it.

Urine testing for early identification of employees with drug problems was seen as an effective tool in such programs.

Such screening, however, should always be carried out "with maximum respect for confidentiality," whether the person being tested is a self-referral or recommended for testing by a company official because of poor job performance, the conferees held.

"Extreme caution also must be encouraged to assure that the collection, handling, and testing procedures are reliable and accurate," the consensus statement advised.

The "Conference on Interdisciplinary Approaches to the Problem of Drug Abuse in the Workplace" was sponsored by the National institute on Drug Abuse March 6-7 in Bethesda, MD.

The experts urged that development of screening programs include input from all perspectives in a company, including labor relations, unions, legal, medical, personnel, security, and employee assistance program.

"The resultant policy should clearly state the employer's rationale and expectations regarding drug use, and actions to be anticipated in response to drug use," the conferees' statement held. "Employees should be explicitly informed of company policy and made aware of the consequences of drug use. Once policy is established, it should should be strictly adhered to and closely monitored to ensure that it is administered fairly and consistently."

Initiating a urine screening program inevitably raises difficult issues. One is balancing the worker's right to privacy with the firm's right to a full day's production and co-workers' rights to a safe work environment.

"Establishing tough drug policies is not an easy task, but I firmly believe that in the long run your businesses, your unions, and the American people will benefit greatly," Dr. Donald Ian Macdonald, Acting Assistant Secretary for Health, told the group.

Another issue is the reliability of testing methods.

"There is no longer any issue about the accuracy of the tests themselves," says NIDA's Dr. Michael Walsh, conference coordinator. "If a laboratory uses well-trained and certified personnel who follow acceptable procedures, the accuracy of the results should be very high. If an initial test shows a sample to be positive, a confirmation test using a different assay method should always be used to verify the first result.

Widespread concern about the toll drug abuse takes on American industy has led to proliferation of drug use screening programs in major firms across the U.S. Among "Fortune 500" companies, testing programs have increased from 3 to 30 percent in the last 3 years. Some firms screen job applicants for drug use as a condition of employment.

Data on the actual extent of drug use at the jobsite are hard to come by, the experts said, but it is assumed that it reflects use in the population as a whole.

Among those just entering the workforce--18-25 year olds--65 percent have used illicit substances, surveys show. Forty-one percent have tried marijuana and 20 percent used it daily for at least one month during adolescence. One out of five has tried cocaine, and 84 percent have used alcohol.

"Clearly, with this history of prior drug use there is cause for serious concern about the American worker's use of drugs and its impact on families, American productivity, and the American economy," Macdonald said.

The total dollar cost to industry from substance abuse cannot be accurately estimated, but losses from accidents, decreased productivity, loss of trained personnel, theft, and security costs are substantial. A recent ADAMHA study estimated the national impact of "reduced productivity" from drug abuse at $33.3 billion in 1983, and from alcohol abuse at $65.6 billion.

"We believe integration of drug screening into programs of treatment, prevention, and drug education in the workplace will prove to be a highly effective way to manage substance abuse problems in industry, and to help reduce these costs," Macdonald said.

He commended business and industry for taking a stand on the issue of drug abuse in the workplace.

He said that a company's drug abuse policy and program should be founded in the rationale that drug use, including alcohol use, is unacceptable in the workplace since it can adversely affect health and safety, productivity and public confidence and trust.

Urine screening tests now on the market are based mainly on scientific research supported by the National Institute on Drug Abuse. The institute currently receives a steady flow of inquiries about use of such tests from companies interested in controlling drug use at the worksite.

NIDA convened the conference of industry, labor, legal and health officials to arrive at a consensus on the best policies, procedures, and strategies to address the problem.

Three panels produced consensus statements in specific areas; legal and security concerns, health and safety, and human relations. The panels also developed recommendations on additional research needed.

Corporate health officials participating in the meeting included Dr. O. Bruce Dickerson, Director of Health and Safety at IBM; Dr. Joseph Cannella, Corporate Medical Director, Mobil Corporation; and Dr. Joseph Schwerha, Director of Industrial Medicine, United State Steel Corporation. Legal experts included Mr. Thomas Smith, Associate Counsel, Lockheed-California Co; Mr. Allan Adler, Legislative Counsel, American Civil Liberties Union; and Mr. John Mason, Chief Counsel, Federal Railroad Administration.

NEW "Q & A" PUBLICATION

NIDA recently published a question and answer booklet on "Employee Drug Screening--Detection of Drug Use by Urinalysis" to provide answers to the most frequently asked questions about how such tests work, their reliability, cost, and other related issues. Excerpts follow:

Q. Is urine screening for drugs legal?

A. At the present time no Federal or State constitutional provision of law directly prohibits the use of drug detection or urine screening programs. Issues of civil rights, discrimination, etc., argue strongly for a well-thought-out policy which carefully considers the need for unbiased, accurate, and legally defensible screening for the job in question.

Q. What level of drug in the urine indicates an individual is impaired?

A. Although urine screening technology is extremely effective in determining previous drug use, the positive results of a urine screen can not be used to prove intoxication or impaired performance. Inert drug metabolites may appear in urine for several days, even weeks [depending upon the drug], without related impairment. However, positive urine screens do provide evidence of prior drug use.

Q. How reliable are urinalysis methods?

A. A variety of methods are available to laboratories for drug screening through urinalysis. Most of these are suitable for determining the presence or absence of a drug in a urine sample. Accuracy and reliability of these methods must be assessed in the context of the total laboratory system. Laboratories should maintain good quality control procedures, follow manufacturer's protocols, and perform a confirmation assay on all positives by a different chemical method from that used for the initial screening. Equally important are the procedures that are followed to document how and by whom the sample is handled from the time it is taken from the individual, through the laboratory, until the final assay result is tabulated.

Q & A (Continued)

Q. How can false positive results occur?

A. It is theoretically possible for a substance other than the drug in question to give a positive result in a screening assay. This is sometimes referred to as "cross reactivity." However, most substances which could possibly cause such cross reaction have been evaluated by the companies that developed the tests and found not to interfere. Generally, the screening assays available today are highly selective if they are properly used. False positive results can also occur due to human error. This is directly dependent on the experience of the laboratory personnel conducting the test and on the laboratory quality control procedures and confirmation procedures any good laboratory imposes to catch such errors.

Q. Can passive inhalation of marijuana smoke lead to a positive urine even if the person did not smoke a joint?

A. Inadvertent exposure to marijuana is frequently claimed as the basis for a positive urine. Passive inhalation of marijuana smoke does occur, and can result in detectable body fluid levels of THC [tetrahydrocannabinol, the primary pharmacological component of marijuana] in blood and of its metabolites in urine. Clinical studies have shown, however, that it is highly unlikely that a nonsmoking individual could inhale sufficient smoke by passive inhalation to result in a high enough drug concentration in urine for detection at the cutoff of currently used urinalysis methods.

Q. How long after marijuana is used can such use be detected?

A. Metabolites of the active ingredients of marijuana may be detectable in urine for up to 10 days after a single smoking session. However, most individuals cease to excrete detectable drug concentrations in 2-5 days. Metabolites can sometimes be detected several weeks after a heavy chronic smoker [several cigarettes a day] has ceased smoking.

Q. How long after use can cocaine/heroin/phencyclidine be detected by urinalysis?

A. The sensitivity of urine assay methods generally available today allows detection of cocaine use for a period of 1-3 days and heroin or phencyclidine [PCP] use for 2-4 days. These detection times would be somewhat lengthened in cases of previous chronic drug use but probably to no more than double these times.

For a copy of the NIDA booklet on "Employee Drug Screening" write National Clearinghouse for Drug Abuse Information, P.O. Box 416, Kensington, MD 20795.

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HYPOGLYCEMIA

"...80% of tested alcoholics exhibited abnormal glucose tolerance..."

A common theme in the nutrition education materials provided by programs is the link between hypoglycemia [low blood sugar] and alcoholism. First Step of Sarasota provided an article by Jack Joseph Challem and Renate Lewin titled "Nutrition Conquers Alcoholism and Drug Abuse" [Let's Live, March 1982). The authors state, "The most common cause of alcoholism is undiagnosed hypoglycemia. The connection is so strong that Robert E. Atkins, M.D., a leading authority on blood sugar disorders, suspects that both diseases may be genetically transmitted by the same chromosomes that also control the tendency to develop diabetes. He has discovered that 80 percent of tested alcoholics clearly exhibit abnormal glucose tolerance, suggesting existence of a cross addiction between alcohol and sugar."

The article presents several research findings on the role hypoglycemia plays in some kinds of drug abuse. According to Dr. Michael Lesser, a psychiatrist specializing in nutritional roots of emotional illnesses, "marijuana depletes the liver of stored glycogen, and therefore can start the body on a roller coaster of erratic blood glucose levels." He also notes that, "many marijuana users experience the "munchies", compulsive eating in an attempt to replenish glycogen stores. As often as not, these food cravings entail further indulgence in sweet, junk goods which aggravate hypoglycemia."

The article notes this research also correlates closely with the growing field of clinical ecology and allergy/addiction syndromes. William Philpott, M.D. has observed in Brain Allergies [Keats Publishing, Inc., 1981] "that ingestion of allergens can derange blood sugar, causing both hypoglycemia and diabetes."

For more information about current research being conducted on this topic, you may contact:

The Huxley Institute for Biosocial Research
1114 First Avenue
New York, New York 10021

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HEREDITY THE KEY
Think Link Weakened by Alcoholism
[Alcoholism and Addiction, March-April 1986]

Women are just as susceptible as males to the detrimental heredity effects of alcoholism, a new study shows.

Based on measurements of cognitive and perceptual motor levels, the data suggest that significant differences occur in the abilities to verbalize, think abstractly or problem solve when comparing women with alcoholics in the immediate family and those without that link.

The study, conducted at the University of Oklahoma Health Sciences Center, reveals that females who were not alcoholic themselves but who had an alcoholic parent or sibling scored considerably lower on the battery of tests than did females, either alcoholic or non-alcoholic, who did not have an alcoholic in the immediate family.

The study included middle-aged women of the same education level who fell into four groups: 1) alcoholic women who had a parent or sibling who was also alcoholic; 2) non-alcoholic women who had an alcoholic parent or sibling; 3) alcoholic women who had no other alcoholic in the immediate family; and 4) non-alcoholic women with no family history of alcoholism. Those with an alcoholic family member were categorized as "family history positive;" those without an alcoholic parent, brother or sister were "family history negative."

All were given extensive neuropsychological tests measuring learning/memory, abstracting/problem solving, and verbal and perceptual-motor performance.

This finding in particular suggests that female offspring of an alcoholic may be born with central nervous system changes and neuropsychological deficits, whether or not they themselves develop alcoholism. Such results tend to refute earlier beliefs that the hereditary factors of alcoholism for female is not as strong as for males.

Heredity the Key (Continued)

Instead the results from this study suggest that alcoholism is an appreciable hereditary component in females as well as in males, Dr. Parsons contends.

While skeptics may claim these findings could relate to environmental factors such as poor nutrition of inadequate medical care for childhood diseases, little difference was found between the scores of those with alcoholic parents and those with alcoholic siblings.

When positive family history is compounded by chronic alcohol consumption, the impairment is most pronounced, which appears to support the notion of the independent, addictive debilitating effects of alcoholism and heredity.

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COMINGS AND GOINGS

WELCOME ABOARD!

MARK CLARK

We would like to introduce our new staff member at ADAD. Mark Clark was hired March, 1986 to fill the Evaluator II position. He will assist in the program evaluations and certification panels. His background in the field includes 5 years employment at Flathead Valley Chemical Dependency Clinic, where his responsibilities involved supervising the Drug Program and counseling adolescent clients. He completed a one year counselor training program at Glasgow CDC in 1980, and has a B.A. Degree in interpersonal communication from the University of Montana, in 1977. Mark was the 22nd person to become certified for chemical dependency counseling in the State of Montana.

Mark is a 33 year old native Montanan, born and raised in Great Falls. He married his wife, Peggy, in 1981 and they have 2 sons, Ryan and Kyle. He enjoys camping trips with his family in the summer, and cross-country skiing in the winter. They enjoy the mountains, lakes and streams of Montana.

Chemical dependency is a personal issue for Mark, both from the perspective of being a family member and from his own use. He has been actively involved in chemical dependency related support groups for his own recovery needs. 1986 is his 10th year of sobriety.

Although Mark's areas of expertise are drug clients and teenagers, he is well rounded, with experience working with alcoholics and chemically dependent people of all ages and backgrounds. He has worked in in-patient and out-patient programs and had extensive experience in evaluations, group facilitating, individual counseling, DUI/ACT, MIP, and outreach. His current experience from working in the field will add an important perspective to the evaluation. During March and April he participated in 6 program evaluations and will be involved in many more this year. He looks forward to observing all of the various programs and meeting the people who are providing treatment services around the state. Welcome aboard Mark!!

DIANA MANN

Diana Mann has been appointed as the new chemical dependency counselor with the Boyd Andrew Dependency Care Center in Choteau.

Ms. Mann is a graduate of the University of Minnesota where she received her Masters Degree in Social Work. She is also a licensed clinical social worker and operated a private Family Counseling Center in Great Falls before coming to Choteau.

BOB MacCONNEL resigned from ADAD December, 1985. We at ADAD wish Bob the best in the future.

If you have new staff or "old" staff members and would like them acknowledged in the Habit, send a short biography to the editor.

From the Editor:

Articles printed in the Habit don't necessarily reflect the opinions of the Editor or ADAD staff. We would encourage anyone to send in comments regarding any of the articles or any other pertinent area in the chemical dependency field. We will attempt to make space available in the Habit for these comments.

There have been numerous requests for addresses of publications used in the Habit.

ADAMHA News
Department of Health and Human Services
Public Health Service
Alcohol, Drug Abuse and Mental Health Administration
Rockville, MD 20857

PULSE BEATS
Insurance Field Co.
P.O. Box 18630
Louisville, KY 40218

THE JOURNAL
Addiction Research Foundation of Ontario
33 Russell Street
Toronto, Ontario M5S 251

THE ADDICTION LETTER
Manisses Communication Group, Inc.
P.O. Box 3357
Wayland Square
Providence, RI 02906-0357

Prevention Pipeline
Prevention and Public Education Branch
National Institute on Alcohol Abuse and Alcoholism
Room 16C-14, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857